**Suspected Testicular (Urological) Cancer Referral Form**

**Cancer 2 Week Wait Referral**

|  |  |
| --- | --- |
| **Referrer Details** | **Patient Details** |
| Name: | Name: | DOB: |
| Address: | Address: | Gender: |
| Hospital No.: |
| NHS No.: |
| Tel No: | Tel No. (1): | *Please check telephone numbers* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning difficulties)? | Capacity concerns? |
| Decision to Refer Date: | Translator Required: Yes[ ] No [ ] Language: | Mobility: |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

|  |
| --- |
| Please confirm that the patient is aware that this is a suspected cancer referral and that the two week wait referral leaflet has been given:[ ] Yes [ ] No |
| Date(s) that patient is unable to attend within the next two weeks*If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

|  |
| --- |
| **Clinical details***Please detail your conclusions and what needs excluding or attach referral letter.* |

|  |
| --- |
|  |
|  |
| **Testicular cancer**[ ]  non-painful enlargement or change in shape or texture of the testis (consider).**Please provide: FBC, U&E, α-FP, β-HCG, LDH (< 8 weeks old)***If swelling is clearly separate from Testis on examination, it is unlikely to be a testicular tumour. Consider ultrasound before referral. Always perform transillumination to exclude benign epididymal cyst(s). Consider a direct access ultrasound scan for a scrotal mass that does not transilluminate or when the body of the testis cannot be easily distinguished on examination (e.g. large hydrocele).* |
| *.* |

|  |  |
| --- | --- |
| **Smoking status** | **WHO Performance Status:** [ ]  **0** Fully active[ ]  **1** Able to carry out light work[ ]  **2** Up & about 50% of waking time[ ]  **3** Limited self care, confined to bed/chair 50%[ ]  **4** No self care, confined to bed/chair 100% |
| **BMI if available** |

**Please attach additional clinical issues list from your practice system**

|  |
| --- |
| **Details to include**Current Medication, significant issues, allergies, relevant family history, smoking & alcohol status and morbidities |

|  |
| --- |
| **Trust Specific Details** |

|  |
| --- |
| ***For hospital to complete*** UBRN: Received date: |

Please send **via ERS**